



MISSOURI VETERANS COMMISSION
MISSOURI VETERANS HOME
ADMISSION MEDICAL INFORMATION

<input type="checkbox"/> CAMERON	<input type="checkbox"/> ST. JAMES
<input type="checkbox"/> CAPE GIRARDEAU	<input type="checkbox"/> ST. LOUIS
<input type="checkbox"/> MEXICO	<input type="checkbox"/> WARRENSBURG
<input type="checkbox"/> MT. VERNON	

NAME		DATE
INDIVIDUAL PROVIDING INFORMATION	RELATIONSHIP TO RESIDENT	TELEPHONE

SELF-CARE STATUS (CHECK LEVEL OF ASSISTANCE NEEDED)

	NO HELP NEEDED	NEEDS SUPERVISION	A LITTLE ASSISTANCE	A LOT OF ASSISTANCE	TOTAL ASSISTANCE
Can the applicant feed him/herself?					
Can the applicant dress him/herself?					
Can the applicant bathe him/herself?					
Can the applicant transfer him/herself?					
Does the applicant walk?					

SELF-CARE STATUS (CHECK APPROPRIATE ANSWER)

		YES	NO
EATING	Any difficulty chewing or swallowing? IF YES, DESCRIBE	<input type="checkbox"/>	<input type="checkbox"/>
	In the last 3 months, has there been a decline in the ability to feed self? COMMENTS	<input type="checkbox"/>	<input type="checkbox"/>
	PLEASE LIST SPECIAL DIET ORDERS		
	PLEASE LIST ANY FOOD ALLERGIES		
WEIGHT	Any changes in weight in past month?	<input type="checkbox"/>	<input type="checkbox"/>
	Any changes in weight in past 6 months? IF YES, DESCRIBE	<input type="checkbox"/>	<input type="checkbox"/>
	USUAL ADULT BODY WEIGHT (AVERAGE WEIGHT OVER PAST 2 YEARS)		
DRESSING	In the last 3 months, has there been a decline in the ability to dress self? COMMENTS	<input type="checkbox"/>	<input type="checkbox"/>
WALKING	Does the applicant need assistance? If so, how much?	<input type="checkbox"/>	<input type="checkbox"/>
	Does the applicant use any of the following (check one): <input type="checkbox"/> cane, <input type="checkbox"/> walker, <input type="checkbox"/> wheelchair, <input type="checkbox"/> gerichair?	<input type="checkbox"/>	<input type="checkbox"/>
	In the past month, has the applicant fallen?	<input type="checkbox"/>	<input type="checkbox"/>
	In the past 6 months, has the applicant fallen?	<input type="checkbox"/>	<input type="checkbox"/>
	COMMENTS		
BOWEL/BLADDER	Is the applicant able to control bladder?	<input type="checkbox"/>	<input type="checkbox"/>
	Does the applicant use a urinary catheter?	<input type="checkbox"/>	<input type="checkbox"/>
	Does the applicant have a history of urinary tract infections?	<input type="checkbox"/>	<input type="checkbox"/>
	Has the applicant been hospitalized or treated for urinary tract infections in the past 6 months? IF YES, WHEN?	<input type="checkbox"/>	<input type="checkbox"/>
	In the past 3 months, has there been a decline in ability to control bladder?	<input type="checkbox"/>	<input type="checkbox"/>
	Is the applicant able to control bowels?	<input type="checkbox"/>	<input type="checkbox"/>
	Does the applicant have a history of constipation?	<input type="checkbox"/>	<input type="checkbox"/>
MENTAL	Is the applicant confused?	<input type="checkbox"/>	<input type="checkbox"/>
	Does the applicant wander?	<input type="checkbox"/>	<input type="checkbox"/>
	Is the applicant combative?	<input type="checkbox"/>	<input type="checkbox"/>
	In the past 3 months, has there been a decline in memory and/or decision making? COMMENTS	<input type="checkbox"/>	<input type="checkbox"/>
	Any sleeping problems? IF YES, DESCRIBE	<input type="checkbox"/>	<input type="checkbox"/>
	In the past 3 months, has there been a decline in mood and/or behavior? IF YES, DESCRIBE	<input type="checkbox"/>	<input type="checkbox"/>

SELF-CARE STATUS (CHECK APPROPRIATE ANSWER)		YES	NO
COMMUNICATION ABILITY	Can speak	<input type="checkbox"/>	<input type="checkbox"/>
	Can write	<input type="checkbox"/>	<input type="checkbox"/>
	Understands speaking	<input type="checkbox"/>	<input type="checkbox"/>
	Understands writing	<input type="checkbox"/>	<input type="checkbox"/>
	Understands gestures	<input type="checkbox"/>	<input type="checkbox"/>
	Understands English	<input type="checkbox"/>	<input type="checkbox"/>
	If no, state language spoken:		
	Does the applicant have any difficulties with speech?	<input type="checkbox"/>	<input type="checkbox"/>
	Does the applicant have any difficulties with hearing?	<input type="checkbox"/>	<input type="checkbox"/>
	Does the applicant have any difficulties with eyesight?	<input type="checkbox"/>	<input type="checkbox"/>
In the past 3 months, has there been a decline in ability to express him/herself, understand or hear?		<input type="checkbox"/>	<input type="checkbox"/>
COMMENTS			
Does the applicant have any skin breakdowns or bed sores?		<input type="checkbox"/>	<input type="checkbox"/>
OXYGEN	Does the applicant use oxygen?	<input type="checkbox"/>	<input type="checkbox"/>
	IF YES, DESCRIBE HOW OFTEN?		
	HOW MANY LITERS OF OXYGEN NEEDED?		
	Any respiratory treatments?	<input type="checkbox"/>	<input type="checkbox"/>
IF YES, DESCRIBE			
Does the applicant have pain daily?		<input type="checkbox"/>	<input type="checkbox"/>
IF YES, DESCRIBE PAIN AND TREATMENTS			
Has there been any new diagnosis since the initial application?		<input type="checkbox"/>	<input type="checkbox"/>
IF YES, DESCRIBE			
In the past 3 months, has the applicant been hospitalized?		<input type="checkbox"/>	<input type="checkbox"/>
IF YES, WHERE			
In the past 3 months, has the applicant been seen in the ER?		<input type="checkbox"/>	<input type="checkbox"/>
IF YES, WHERE			
Any visits to psychologist, psychiatrist, or social worker?		<input type="checkbox"/>	<input type="checkbox"/>
IF YES, SEEN BY WHOM, WHEN, WHERE?			
HISTORY	Resident history 5 years prior to entry	<input type="checkbox"/>	<input type="checkbox"/>
	Prior stay at this nursing home?	<input type="checkbox"/>	<input type="checkbox"/>
	Stay in other nursing home?	<input type="checkbox"/>	<input type="checkbox"/>
	Other residential facility (board and care home, assisted living, group home, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
	Mental health/psychiatric setting?	<input type="checkbox"/>	<input type="checkbox"/>
	Mentally retarded/developmentally disabled?	<input type="checkbox"/>	<input type="checkbox"/>
	None of the above	<input type="checkbox"/>	<input type="checkbox"/>
In the year prior to date of entry to this nursing home, or year last in community if now being admitted from another nursing home, does the applicant (check appropriate answer):			
CYCLE OF DAILY EVENTS		YES	NO
Stay up late at night (after 9 p.m.)?		<input type="checkbox"/>	<input type="checkbox"/>
Nap regularly during day (at least 1 hour)?		<input type="checkbox"/>	<input type="checkbox"/>
Go out 1 or more days a week?		<input type="checkbox"/>	<input type="checkbox"/>
Stay busy with hobbies, reading or fixed daily routine?		<input type="checkbox"/>	<input type="checkbox"/>
Spend most of time alone or watching TV?		<input type="checkbox"/>	<input type="checkbox"/>
Move independently indoors (with assistive devices, if used)?		<input type="checkbox"/>	<input type="checkbox"/>
Use tobacco products, at least daily?		<input type="checkbox"/>	<input type="checkbox"/>



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EATING PATTERNS	YES	NO
Distinct food preference?	<input type="checkbox"/>	<input type="checkbox"/>
Eats between meals?	<input type="checkbox"/>	<input type="checkbox"/>
Uses alcoholic beverages at least weekly?	<input type="checkbox"/>	<input type="checkbox"/>
ACTIVITIES OF DAILY LIVING	YES	NO
In bedclothes much of the day?	<input type="checkbox"/>	<input type="checkbox"/>
Wakens to toilet all or most nights?	<input type="checkbox"/>	<input type="checkbox"/>
Has irregular bowel movement pattern?	<input type="checkbox"/>	<input type="checkbox"/>
Prefers showers for bathing?	<input type="checkbox"/>	<input type="checkbox"/>
Bathe in the p.m.?	<input type="checkbox"/>	<input type="checkbox"/>
Bathe in the a.m.?	<input type="checkbox"/>	<input type="checkbox"/>
INVOLVEMENT PATTERNS	YES	NO
Daily contact with relatives/close friends?	<input type="checkbox"/>	<input type="checkbox"/>
Usually attends church, temple, synagogue, etc.?	<input type="checkbox"/>	<input type="checkbox"/>
Finds strength in faith?	<input type="checkbox"/>	<input type="checkbox"/>
Daily animal companion/presence?	<input type="checkbox"/>	<input type="checkbox"/>
Involved in group activities?	<input type="checkbox"/>	<input type="checkbox"/>
IS THERE ANY OTHER INFORMATION CONCERNING THE APPLICANT THAT WOULD BE HELPFUL?		
NAME OF APPLICANT		
SIGNATURE		DATE